CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

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To: All Home and Community Based Waiver Providers

From: Earl Gresham
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RE: Requests for Goods, Services, or Medical Equipment

The Department for Medicaid Services (DMS) wants to remind providers that Home and Community Based waivers are the payer of last resort for all Medicaid goods, services, and medical equipment. Here is the process providers should follow.

- **How should providers request goods, services, and/or medical equipment for adult waiver participants?**
  - When a good, service, or piece of equipment is available through state plan, providers should request it through state plan first.
  - Providers can access state plan goods, services, and equipment by making the request using an agency that provides the needed good, service, or piece of equipment for state plan.
    - For example, providers should request supplies for waiver participants receiving home health or private duty nursing (PDN) through the home health or PDN agency. Providers can request those supplies through waiver if a participant is not receiving home health or PDN services.
    - Similarly, if state plan covers a piece of durable medical equipment (DME), it should be requested that way first.
  - For questions about DME, providers can call Sheldon Robinson with the DMS Division of Policy and Operations at 502-564-6890, ext. 2222.

- **How should providers request goods, services, and/or medical equipment for waiver participants under 21?**
  - Providers should make those requests through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. EPSDT can approve, based on a child's condition/presentation, medically necessary state plan services that state plan would otherwise deny.
    - For example, DME only covers nutritional supplements when that is the sole source of nutrition. If determined medically necessary for a child under 21, nutritional supplements may be prior authorized even if they are not the sole source of nutrition

        - Vision, hearing, and dental requests for participants younger than 21 should also go through state plan.
    - For questions about EPSDT, providers can call Crystal Myatt, RN with the DMS Division of Program Quality and Outcomes at 502-564-9444.

- **When can a provider request a good, service, and/or medical equipment through the waiver?**
    - A provider can request a good, service, or medical equipment through waiver if:
        - State plan has already denied the request.
        - The good, service, or medical equipment is not covered under state plan and meets regulatory criteria.
            - For example, vision, hearing services, and non-preventative dental can be requested through waiver for participants older than 21 because those are not covered under state plan.

- **What do providers need to know about requesting goods, services, and/or medical equipment through waiver?**
    - Requests need to be submitted via the Medicaid Waiver Management Application (MWMA). The submission must include a denial letter from the request made through state plan. Providers can upload a MAP 95 to speed up approval.
    - DMS will use the remaining fee schedules to price goods, services, DME, dental, and vision. Those can be found at: https://chfs.ky.gov/agencies/dms/dmps/psb/Pages/feesrates.aspx
    - Providers will need to submit three quotes for goods, services or medical equipment not listed on the fee schedules. This includes environmental home modifications or specialized medical equipment.

DMS is aware of inappropriate lack of information (LOI) requests sent for goods and services submissions. We are addressing the issue with DXC Technology and Carewise Health.

If you have questions, please contact DMS – Division of Community Alternatives at 502-564-5560.